TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOWNTOWN PERFORMANCE MEDICAL

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-15-1197-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
DECEMBER 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The denial is invalid as the original bill was submitted on **3/3/14** for DOS **1/20/14** and **2/6/14**, on **7/8/14** for DOS **5/8/14-5/28/14** and **8/6/14** for DOS **6/24/14**. Fax confirmation shows the bill was successfully transmitted. Reconsideration was sent on **9/11/14** and **10/27/14** for DOS **1/30/14** and **2/6/14**, **8/14/14** and **11/3/14** for DOS **5/8/14-5/28/14** and **9/15/14** and **10/13/14** for DOS **6/24/14** and subsequently denied for the same reason."

Amount in Dispute per Updated Table: $1,129.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR request, the bill was sent for additional review. It was determined that additional payments in the amount of $228.96 and $3,379.20 are owed."

Response Submitted by: ACE/ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2014	CPT Code 97545-WH (2 hours) Work Hardening	$153.60	$716.80
May 16, 2014 May 23, 2014	CPT Code 97546-WH (6 hours) Work Hardening	$460.80/ea	
June 24, 2014	CPT Code 97750 Physical Performance Evaluation	$54.00	$52.76
TOTAL		$1,129.20	$769.56

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §134.600 requires preauthorization for non-exempt work hardening programs.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed work hardening program..
5. 28 Texas Administrative Code §134.203 sets the reimbursement guidelines for professional services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - TX02, 62-No proof of Pre-Auth.
   - Previous recommended payment amount on line.
   - Previous recommended history on DCN(s): 24371010 = $0.00.
   - This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 197-Precertification/authorization/notification absent.
   - 29-The time limit for filing has expired.
   - 18-Duplicate claim/service.

Issues

1. Does a preauthorization issue exist?
2. Does a timely filing issue exist?
3. Is the requestor entitled to additional reimbursement for the work hardening program?
4. Is the requestor entitled to reimbursement for the physical performance evaluation?

Findings

1. The respondent denied reimbursement for the work hardening program based upon a lack of preauthorization.

   28 Texas Administrative Code §134.600(p) Non-emergency health care requiring preauthorization includes (4) all work hardening or work conditioning services requested by: (A) non-exempted work hardening or work conditioning programs; or (B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection."

   On May 2, 2014, the respondent's representative MediCall gave preauthorization approval for 80 hours of work hardening program to be rendered between April 29, 2014 and June 28, 2014. The disputed services were rendered from May 8, 2014 through May 28, 2014; therefore, the respondent's denial is not supported because the services in dispute were preauthorized.

2. The respondent also denied reimbursement for the work hardening program and the physical performance evaluation based upon timely filing.

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   The requestor submitted a copy of the letter requesting reconsideration dated August 14, 2014 via certified: 7004 0750 0001 3095 8175 that supports the disputed services were submitted timely in accordance with Texas Labor Code §408.027(a); therefore, reimbursement is recommended per Division rules and fee guideline.

3. A review of the submitted medical bills indicates that the requestor billed for a non-CARF accredited work hardening program with codes 97545-WH and 97546-WH.

   28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   28 Texas Administrative Code §134.204(h)(3)(A) and (B) states "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97545-WH and 97546-WH for fourteen (14) units on the disputed dates of service. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (3)(A) and (B), the MAR for a non-CARF accredited program is $51.20 per hour ($64.00 X 80%). $51.20 times the 14 hours billed is $716.80. The respondent paid $0.00. The difference between the MAR and amount paid is 716.80. This amount is recommended for additional reimbursement.

4. On June 24, 2014, the requestor billed for a physical performance evaluation with CPT code 97750.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77004, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston, Texas".

The 2014 DWC conversion factor for this service is 55.75.

The 2014 Medicare Conversion Factor is 35.8228.

The Medicare Participating Amount for this code is $33.90

Using the above formula the Division finds the MAR is $52.76. The respondent paid $0.00. As a result, $52.76 is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $769.56.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $769.56 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/21/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.